Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HCA TEXAS ORTHOPEDIC HOSPITAL
C/O HOLLAWAY & GUMBERT
3701 KIRBY DRIVE STE 1288
HOUSTON TX 77098-3926

Carrier's Austin Representative Box
#19

MFDR Date Received
SEPTEMBER 12, 2005

Respondent Name
AMERICAN HOME ASSURANCE CO

MFDR Tracking Number
M4-06-0819-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated September 9, 2005: "per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%...In closing, it is the position of HCA Texas Orthopedic Hospital that all charges relating to the admission of [Claimant] are due and payable as provided for under Texas law."

Amount in Dispute: $37,168.32

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated September 30, 2005: "This firm has been retained to represent the Carrier in the above-referenced matter…Enclosed please find documents responsive to this issue for your review…no additional payment was recommended towards the amount in dispute."

Response Submitted by: Hoffman Kelley LLP

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 14, 2004 through September 21, 2004	Inpatient Hospital Services	$37,168.32	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 921 – Complex bill – reviewed by medical cost analysis team – ur/je
- 426 – Reimbursed to fair and reasonable.
- 16 – This charge is being disputed. Please provide a copy of the documentation which supports this charge.
- 859 – Re-eval letter of explanation will be mailed under separate mailout.
- 353 – This charge was reviewed per the attached invoice.
- 360 – Allowance for this procedure was made at the 'fair and reasonable' amount for this geographical area.
- F – Fee schedule MAR reduction.
- M – No MAR
- W1 – Workers Compensation state fee schedule adjustment.
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- MCA re-eval requests pmnt 75% audited charges, per rule 134.401(c)(6)(a). Please note: bill not subject to ACIHFG, as trauma admit. Reimbursed fair & reasonable in accordance with CMI standard & estab protocol; see attached letter
- *Preferred Provider Organization: SWMPN/ROCKPORT

Findings

1. The insurance carrier reduced or denied disputed services with reason code "Preferred Provider Organization: SWMPN/ROCKPORT." No documentation was provided to support that a reimbursement rate was negotiated between the workers' compensation insurance carrier American Home Assurance and HCA Texas Orthopedic Hospital prior to the services being rendered; therefore, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.9.
3. The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in 28 Texas Administrative Code §134.401(c)(6). The requestor asserts in the position statement that "per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%." 28 Texas Administrative Code §134.401(c)(6), effective August 1, 1997, 22 TexReg 6264, states, in part, that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a code specified in 28 Texas Administrative Code §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to 28 Texas Administrative Code §134.1.
4. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that

discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

- The requestor's position statement asserts that "per Rule 134.401(c)(6)(A)(i)(iii), once the bill has reached the minimum stop-loss threshold of $40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%."
- The requestor does not discuss or explain how additional payment of $37,168.32 would result in a fair and reasonable reimbursement.
- The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	04/16/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.